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LINGUISTIC DIVERSITY, EQUITY AND HEALTH: ‘DO YOU SPEAK COVID-19?’

Abstract

With many languages of the world becoming marginalized, discriminated against and at times even facing extinction, the linguistic landscape of the medical and health-care context suffers many challenges. Most prominently, when medical / health staff and their patients do not speak the same language, health-care disparities arise. With COVID-19 sweeping through the world, language barriers multiplied, access to information became a privilege conditional upon competence in English or one of the major world languages, people’s perception of the pandemic became confused and health care was adversely affected. This paper attempts a review of some of the research conducted on the impact of language obstacles on patients and the health care they receive, and the impact of linguistic inequities on the particular case of health care during the pandemic of COVID-19. Emphasizing the indispensable need for linguistic rights, the paper calls for a redefinition of health in linguistic terms, proposing the term “linguistic health” to address relevant issues. Strategies for multilingual health care and a medical responsiveness coupled with linguistic responsiveness are deemed an essential prerequisite for an all-inclusive global health culture.

Keywords

Linguistic Rights, Linguistic Diversity, Linguistic Health, Health Equity, Health Care, COVID-19

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1. INTRODUCTION

It is estimated that the world hosts no less than 6000 to 7000 languages today, with a third of these spoken by communities of less than a thousand speakers. Establishing itself as the global lingua franca, English dominates the world scene at around 1.268 billion speakers in 2019 (Statista, 2021). This is followed by Chinese (1.117 billion speakers), Hindi (615 million speakers), Spanish (534 million speakers), French (280 million speakers) and Arabic (274 million speakers). At the other end of the continuum, there are endangered languages. On 8th March 2021, the last native speaker of the rare Bering dialect of the Aleunt language died in Russia, burying with her an entire culture.

This situation has given rise to global concern, indeed alarm. With currently a total of 573 known languages having become extinct, linguistic rights are becoming firmly established as inseparable from basic human rights. They are no longer limited to issues of minority rights; in fact, the UNESCO website argues that There is a fundamental linkage between traditional knowledge (TK) related to biodiversity. Local and indigenous communities have elaborated complex classification systems for the natural world, reflecting a deep understanding of their local environment. This environmental knowledge is embedded in indigenous names, oral traditions and taxonomies, and can be lost when a community shifts to another language. (UNESCO, 2017).

Language or linguistic rights have, thus, become a political and cultural imperative. In the globalized world of the twenty-first century, linguistic rights are not only integral to basic human rights, and essential in the preservation of both our linguistic/cultural diversity and our biological diversity, but indeed, they are also foundational towards a healthier world. The numerous declarations, treaties and conventions issued by various bodies, such as the Framework Convention for the Protection of National Minorities, The European Charter for Regional or Minority Languages, The Universal Declaration of Linguistic Rights, to mention but a few, may stipulate equal rights to freedom of expression, the right to education in the mother-tongue, on to the right to historicity and self-identification. The Universal Declaration of Linguistic Rights also stresses the need to disregard any classificatory terms that may come across as discriminatory rather than taxonomic: “the Declaration proclaims the equality of linguistic rights, without any non-pertinent distinctions between official/non-official, regional/local, majority/minority, or modern/archaic languages.” (Committee, 1998, p. 12) There is no doubt that such designations construct languages into hierarchical statuses of superiority and inferiority, whether political, cultural, social or historical.

2. BACKGROUND

Further elaborating on the need to establish and maintain linguistic peace, the *Declaration* is deemed an essential text that aims “to correct linguistic imbalances with a view to ensuring the respect and full development of all languages and establishing the principles for a just and equitable linguistic peace throughout the world as a key factor in the maintenance of harmonious social relations.” (Committee, 1998, p. 12) What all conventions, treaties and the *Declaration* seem to overlook, however, is an equivalent focus on what may be termed “linguistic health”. There are a number of approaches to language as a social determinant of health, with abounding discussions and explorations of the need for language proficiency in the field of health-care services. However, there does not seem to be a general consensus on establishing a possible dimension to defining health as a linguistic construct that allows members of a speech community to perceive of health/illness, access to health care, expression of their pain and physical state, communication of preventive measures, and overcoming language barriers, whether resulting from situations of linguistic diversity or due to the rapid introduction and use of new terminology. “Linguistic imbalances” in this case create major forms of discrimination against speech communities that do not have direct access to the world’s lingua franca, or who are limited to available translations in their native tongues, regardless of speed and accuracy.

One case in point is the WHO “Linguistic Collaborations” initiative. As stated on their website (https://www.who.int/servicedeliverysafety/areas/linguistic/en/), the main objective of the initiative is “To create a common platform across WHO in the area of linguistic collaboration for action to improve Universal Health Coverage and Health system.” It is described as a mechanism that seeks to aid in achieving universal health coverage through establishing “Global health communication … among professionals, policy-makers and others from different regional or linguistic groups” while at the same time “Meeting the health information needs of individual

people and health workers in a language they can understand." This consciousness of the indispensable necessity to make health information available in the languages of the world is, however, defeated by the fact that much of the work done seems to remain accessible only in four European languages – English, French, Portuguese, and Spanish.

3. STATEMENT OF THE PROBLEM

Conceptions of health, illness, pain and relevant needs for health services and care are partially linguistic constructs. The (in-)ability to verbalize how one feels, to describe the locus, nature and intensity of their pain/symptoms, and consequently to communicate what is needed may lead to serious language barriers between patients and health-care providers. Not finding the necessary words in their mother-tongue to express their state on the continuum of health/illness disadvantages many speech communities who do not have immediate access to English or any of the "official" European languages. Despite efforts to translate much of the updates in the medical field, there is no doubt that the production of new knowledge will continue to rely upon the usage of English and major world languages, while translation lags behind due to various reasons. The recent COVID-19 pandemic is an excellent case study to illustrate the overwhelming linguistic discrimination that swept through the world accompanying such phenomena as infodemics, misinformation, and lack of information.

4. RESEARCH QUESTIONS

This paper seeks to explore these issues by addressing the following questions:

1. In what ways are language barriers a challenge to an equitable access to health care?
2. How has the recent COVID-19 pandemic enhanced linguistic gaps and disadvantaged non-English speaking people?

5. EQUITABLE LINGUISTIC HEALTH

The United Nations' Sustainable Development Goal 3 states: "Ensure healthy lives and promote well-being for all at all ages". The situation, however, is not as simple or straightforward as it may seem. Global medical policies and efforts towards a serious enhancement of the health and well-being of respective populations requires accompanying language policies and efforts that make medical and health care services truly accessible to all. The fact that knowledge in the fields of medicine and health care are largely produced, propagated, exchanged, and implemented in the world's major languages, with English as the lingua franca of science and technology at the forefront, has contributed to the creation of a global discourse of the medical community, establishing traditions, conventions and ethics observed in almost every corner of the world. In addition, such traditional scientific/professional discourse assumes a position of authority, which affects cultural hierarchies. This power-relation, unfortunately, also contributes (inadvertently) to adequate attention to and understanding of local epistemologies that are encoded in less prominent languages and vernaculars. In speech communities where access to English recedes, culture-sensitive and culture-specific forms of "medicinal" knowledge are relegated to less "scientific", less authoritative, and less authentic practices.

In a globalized world, the North-South divide becomes even more accentuated. Spiegel, Breilh and Yassi (2015) argue for the need of focusing on language as a "social determination" of health through the adoption of more context-sensitive, and hence more equitable, approaches to medical research, policy and praxis. Through their research project, the authors "strove to merge the theoretical reasoning emergent in the South with the insights and techniques derived from the empirical approaches refined in the North" (n.p.). Extending over a period of six years, the project included "a comprehensive meta-narrative synthesis of published English and Spanish language literature", concluding that such cross-cultural insights can help better understand the emergence and/or reinforcement of disparities.

This correlation between language barriers and health-care disparities has been noted in various recent studies. Researchers at the Institute of Public Health, Washington University, bring the issue into focus in the light of the linguistic landscape of the USA. In their report on the ongoing study they are conducting, Baugh, Wilson, Hirani & Ross (2016) argue for the obvious, though at times indirect, dependence of the effectiveness of patient/health-care provider communication on the dis-/similarities of their respective linguistic and cultural backgrounds. The authors point out that in the US context, various forms of inadvertent linguistic bias may arise,

which in turn has negative impact upon medical and health-care services. They also warn that in many cases medical professionals may find themselves “in circumstances where language barriers are insurmountable in a timely manner” (n.p), which may further disadvantage non-English speakers. One of the most important conclusions the authors reach is the fact that “Effective communication can never be taken for granted under any circumstances, but medical communication is especially important and is most likely to be successful when patients and medical professionals are native speakers of the same language.” (n.p.)

An earlier study has shown similar confirmed results. Ponce, Hays and Cunningham (2006) examined the impact of linguistic disparities in health-care access on elderly adults. The sample of their study included 18,659 adults aged 55 years and above, and it was found that patients with limited English proficiency (LEP) were at higher risk in their ability to access health care. The study, therefore, recommended the necessity to provide two means conducive to the reduction of linguistic barriers and thus improve the health-care access of these disadvantaged groups. The focus of such means should be on integrating language services and training health-care workers in cross-cultural competence.

Similarly, in 2011, researchers at Wayne State University reported that patients suffer less confusion and perceive better health-care quality when their health-care providers speak the same language. One of the researchers commented, “We have the most sophisticated health care system in the world, however, it does little good if patients and providers fail to communicate.” (n.p.) Commenting on the findings of the study, Gonzalez (Gonzalez, Vega, & Tarraf, 2011) points out that non-English speaking patients are often blamed for “not adhering to medical prescriptions and treatments when the problem may be that patients simply don’t understand the clinician.” (n.p.) The main recommendation of the study calls for the need to prioritize the elimination of disparities in health care, in particular linguistic disparities which are expected to increase with the increasing diversification of the linguistic landscape in the USA.

It is no coincidence, then, that (Showstack, Santos, Feuerherm, Jacobson, & Matinez, 2019) published in December 2019 a paper entitled “Language as a Social Determinant of Health: An Applied Linguistic Perspective”. Published on the American Association for Applied Linguistics website, the brief raises two most significant questions: “How can our expertise in applied linguistics and language education make a difference in efforts to reduce health disparities for racial, ethnic, and linguistic minority communities and ultimately work towards health equity for the populations we teach and study? Why is it critical that our profession advocate for renewed attention to language in health care, not merely as a demographic marker, but arguably as one of the most significant (and yet underexplored) social determinants of health in underserved linguistic minority communities?”

If this quick review elaborates on a problematique in what is deemed a well-established medical tradition, it is only fair to wonder what complications may arise with a rapidly unfolding and changing medical situation as created by the novel COVID-19 pandemic.

6. LINGUISTIC HEALTH AT THE TIME OF COVID-19

COVID-19 is unanimously described as an unprecedented calamity that has affected the lives of people the world over. The crisis is not limited to the medical sector, which has been confronted with tremendous challenges to save and safeguard lives; it has affected all other aspects of human existence, posing threats to many economic and social structures. Global responses, however, have been disparate. Since December 2019, medical knowledge and information have multiplied exponentially, giving rise to what is termed an infodemic. With much of the scientific and technical discourse circulating in medical circles, the people of the world have been fostering an insatiable hunger for reliable knowledge and magical health care. Despite the efforts exerted by bodies such as the WHO to provide confirmed updates and guidelines, much of what has trickled down to the people the world over has been hindered by diverse linguistic barriers, disadvantaging those who do not have direct access to English.

The early weeks of the emerging pandemic witnessed a curious change and shift in the designation of the virus/the disease. The process is curious to trace for a number of reasons: first, the fact that the world needed a name for it is indicative of the importance of verbalizing health-related issues; second, as the name changed from its earliest form (“2019 novel coronavirus”), to the official names announced by the WHO on its website, to differentiating between the disease (COVID-19 / Coronavirus disease) and the actual virus (SARS-CoV-2) on 12th February 2020

has often caused confusion between the virus and the disease; third, the media usage of these terms (often interchangeably and at times even irresponsibly) has influenced the down-playing or up-playing of the seriousness of the pandemic. But it was not until 11th March 2020, when the WHO declared the situation as a health emergency and COVID-19 as a pandemic of global reach, that the terms started to acquire a more pressing immediacy.

According to the WHO guidelines of 2015, the Organization is obliged to provide a name for any new diseases, which "did not refer to a geographical location, an animal, an individual or group of people, and which is also pronounceable and related to the disease." (This stands in blatant opposition to ex-President Donald Trump's persistent reference to the disease as the "Chinese virus".)

In an interesting comparative corpus study, Haddad and Montero-Martinez (2020) trace the formative development of the neologism "COVID-19", and conduct a corpus analysis of its most prominent alternatives and their co-text occurrences, and then compare the same linguistic phenomena in Arabic media corpora. Emphasizing the need for conciseness and clarity in the coinage and usage of the scientific/medical term, the authors conclude that "the meronymic term 'coronavirus' is extended worldwide, which may provoke confusion and misunderstanding by laypeople in spite of the urgency of acquiring precise and reliable information." (p. 18) Such discrepancy in terminology can cause great disparities in people's perceptions of the disease, with often detrimental consequences to their health.

The situation is aggravated by the emergency circumstances and overwhelming stress faced by medical and health-care staff. The linguistic requirements for in-patients vs out-patients, for isolated/quarantined patients, for elderly patients with chronic conditions, and for dying patients cover a tremendous range of medical practices each of which necessitates a set of communicative strategies which are often overlooked due to lack of time, medical equipment, trained staff, linguistic proficiency, and/or cultural competence.

Faced with unsurmountable health-care obstacles during the peaking weeks of the first wave of the pandemic, there was much talk about the pressing need to reallocate state budgets, shifting much of state funding from military aspects to medical infrastructures and R&D. In the opening lines of their article, Diamond, Jacobs and Karliner (June 2020) point out that COVID-19 has cast light on "the inequities inherent to our healthcare systems worldwide." (n.p.) Though the article focuses on the case of the 8% of low English proficiency (LEP) communities in the USA, the arguments raised are valid in all LEP communities around the world. Information needs to be made both available and accessible, and the linguistic encoding often poses a major communication barrier. The authors' conclusion reiterates the fact that no one should be left behind in the battle against COVID-19, stating that "Clear communication is a powerful tool in the fight against COVID-19." (n.p.)

With an increasing number of scholarly papers, articles and reports tackling the severity of the issue, there are also a number of initiatives that have been reported by health practitioners in an effort to overcome linguistic disparities and barriers towards a more equitable/collective healing process in the time of COVID-19. One such initiative is proposed by Knuesel, Chuang, Olson and Betancourt (2020) who proposed the formation of the Spanish Language Care Group (SLCG) which aims at providing linguistic support for LEP Spanish-speaking patients in the USA. The idea started with the formation of a team of Spanish-speakers identified among the clinicians at the hospital, who would be called upon to assist in particular with Spanish-speaking COVID-19 patients. The idea soon evolved into "a creative and novel care delivery model, fashioned to prioritize culturally and linguistically competent care." (p. E1)

An alternative proposal focuses on "The Missing Strategy in Addressing Language Barriers" elaborated by Velasquez, Beckman and Roderiguez (2021). The authors argue that language interventions that rely upon interpretation services and "linguistically tailored health information" remain limited and inadequate. In lieu of such services, they recommend the enhancement of English language courses to improve non-English speakers' skills. For the purposes of overcoming language barriers emerging in health-care situations, the authors recommend "[b]olstering language services with health-focused ESL courses [which] may ultimately reduce health care spending and satisfy mandatory community health needs assessment implementation strategies." (p. 94) In terms of linguistic rights, the proposition is in violation on two levels. First, patients affected by COVID-19 will not have the time or energy to attend ESL classes, nor will the illness give them sufficient time to address language barriers before receiving

urgently needed medical care. Second, upholding English courses as the main solution for low English proficiency, especially in a linguistic diversity context, presents further discriminatory attitudes towards speakers of other languages.

Despite efforts to provide official documents on COVID-19 in Arabic, such as the documents translated by the Australian authorities, by the British NHS or by the WHO, there remains, however, a major gap of available information in the local vernaculars and dialects of Arabic. In addition, there is a scarcity of studies conducted on the impact of Covid-19-related language issues on health-care access and services in both Arabic-speaking countries and in countries where Arabic-speakers are a minority or guest community. In comparison, there is a plethora of user-produced content in Arabic on social media platforms and some researchers have started conducting studies on these. One insightful study was conducted by Essam and Abdo (2020) to examine "How do Arab Tweeters Perceive the Covid-19 Pandemic?" through a computational content-based approach. By identifying and analysing the linguistic expressions used by Arabic speakers on Twitter to express their feelings and attitudes towards COVID-19, the researchers isolated a number of predominant themes. Though the researchers covered only a period of 12 weeks of tweets, it is curious to note that they found a high percentage of the tweets falling under the theme of "conspiracism". In addition, "Arab governments and officials were criticised for not taking necessary and timely precautions to fight the outbreak of the virus." (p. 11) There is no doubt that much of the fear and anxiety may have been elevated through what this paper terms linguistic health, namely the timely and transparent access of speakers of different languages to reliable news and information which enhances their perceptions of diseases and pandemics.

8. CONCLUSION

There are many recent references to COVID-19 itself as a new language, with phrases such as "Talk COVID to me" or "Do you speak COVID-19" appearing in titles and headlines. In other words, the pandemic – like any other medicinal or health issue – has given rise to its own lingo, which is essential if we seek to empower people with different languages to construct these conceptions of health and illness adequately. The blatant imbalance in the linguistic landscape of the world has intensified the emergence of linguistic obstacles and barriers, enhancing an already overwhelming state of linguistic discrimination in health-care contexts.

Reviewing some of the most recent research on these issues, it becomes obvious that linguistic rights are no longer merely a political and cultural imperative – they are an indispensable component towards sustainable health. As such, this paper calls for a possible redefinition of health care in the light of linguistic needs as well as an organic integration between health care efforts and languages to address the local and immediate needs of speakers of less global languages. Health equity seems only possible in the light of a linguistic health paradigm which allows the enhancement of people's health literacy. To encode these concepts, this paper proposes the term "linguistic health".

Given the global dominance of English as the lingua franca of science and technology – in this case also of medicine and health care – the paper calls for the promotion of a culture of multilingual health care – patients should not be burdened with the need to expand their linguistic repertoire (in particular being "forced" into learning better English); rather healthcare workers should be able to communicate in the patients' mother-tongue. Though many language-conscious medical and health-care facilities have adopted interpretation services and/or digital translation applications, there is no doubt a pressing need for the development of far-reaching strategies for multilingual healthcare services, in alignment with multilingual/multicultural trends. With full appreciation of the medical responsiveness witnessed in many parts of the world, yet it needs to be coupled with linguistic responsiveness for a linguistic health culture to take root. Last but not least, studies on the current linguistic health status in the Arab World and for Arabic-speaking patients need to be conducted.

Crisis communication requires clarity, immediacy, access and trust. These can only be achieved through a greater appreciation of our linguistic diversity, a keener will to preserve threatened languages and a firmer belief in an equitable linguistic landscape. Ensuring health for all can only be achieved through respecting the linguistic rights and linguistic health of all.

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